

Berwick Surgery

Quality Report

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Date of inspection visit: 1 March 2016

Date of publication: 28/07/2016

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service		Inadequate	
Are services safe?		Inadequate	
Are services effective?		Inadequate	
Are services caring?		Good	
Are services responsive to people's needs?		Good	
Are services well-led?		Inadequate	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Berwick Surgery on Thursday 1 March 2016. Overall the practice is rated as inadequate.

Our key findings across all the areas we inspected were as follows:

- Improvements to patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was limited evidence that the practice was comparing its performance to others.
- Risks to patients were not assessed and managed. For example, there were no risk assessments for fire, COSHH, legionella or infection control.
- We identified a number of gaps in the arrangements for identifying, recording and managing risks and we found many gaps in the record keeping for staff files.
- The practice had a number of policies and procedures to govern activity, but some were overdue a review. For example, the safeguarding policy had not been reviewed since 2012.

- The arrangements for managing medicines, including vaccinations, were not effective to ensure that patients were kept safe.
- Data showed patient outcomes were comparable to the national average. However, exception reporting for patients with long term conditions was higher than CCG and national averages.
- The practice did not have facilities for disabled people and there were no provisions for patients to see a female GP.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.

The areas where the provider must make improvements are:

- Ensure there is a programme of quality improvement to include clinical audits and re-audits are carried out to improve patient outcomes and review exception-reporting data to improve the management of patients with long-term conditions.

Summary of findings

- Ensure risk assessments for fire, infection control, legionella and COSHH are carried out to keep people safe.
- Ensure that recruitment checks comply with Schedule 3 requirements and risk assessments for DBS checks are carried out for staff who carry out chaperoning duties.
- Ensure systems are in place to keep all staff up to date with role specific training, including training in safeguarding, fire safety, infection control, information governance, and Mental Capacity Act
- Ensure effective systems are in place to manage medicines, including vaccines and emergency medicines and that there are systems in place to monitor blank prescriptions
- Ensure formal governance arrangements are implemented, including systems for assessing and monitoring risks, the quality of the service provision and practice specific policies are up to date.

In addition the provider should:

- Review facilities for disabled people and people who are hard of hearing and advertise that translation services were available.
- Review systems to identify carers.

Since inspection, we have received additional information to show some action has been taken to address issues. We will investigate these in our next inspection in six months.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as inadequate for providing safe services and improvements must be made.

- Patients were at risk of harm because systems and processes were not in place in a way to keep them safe. For example, no infection control audit had been carried out since 2012 and we found mould in the vaccine fridge and on the packaging of vaccines.
- There was oxygen available but no masks and we found some medicines and medical appliances were out of date.
- There were no fire risk assessments and only two staff had had fire safety training. There were no records of fire drills being conducted and we found fire extinguishers were dated as due to be checked in 2013.
- Electrical equipment had not been checked since 2012 to ensure the equipment was safe to use.
- The practice could not demonstrate that staff who acted as chaperones had received a Disclosure and Barring Service check (DBS check) and there was no evidence the practice had carried out a risk assessment to determine if this was needed. There were no records of DBS checks for the healthcare assistant.
- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong reviews and investigations were thorough and lessons learned were communicated. For example, training had been identified because of analysis of a significant event.

Inadequate



Are services effective?

The practice is rated as inadequate for providing effective services, as there are areas where improvements should be made.

- Data showed patient outcomes were comparable to the national average. However, the practice had higher than average exception reporting for some clinical indicators. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Including, Chronic Obstructive Pulmonary Disease (COPD) of 36%, diabetes was 32%, cancer related indicators was 33% and chronic kidney diseases of 32%.

Inadequate



Summary of findings

- Knowledge of and reference to national guidelines was inconsistent. The practice did not have a system to ensure that these guidelines were followed through risk assessments, or audits.
- No audits had been carried out and therefore there was no evidence that audit was driving quality improvement in patient outcomes.
- Multidisciplinary working was taking place.

Are services caring?

The practice is rated as good for providing caring services.

Good



- Data from the national GP patient survey showed patients rated the practice similar to others for several aspects of care. For example, 82% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 83% and the national average of 89%.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice did not have an effective system to identify patients who were carers.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. The lead GP is the clinical director for Havering CCG.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice did have wheelchair access, however there were no disabled toilets or induction loop. They did have a translation service.

Summary of findings

- There were two male GPs but no provision was made for patients to see a female GP.

Are services well-led?

The practice is rated as inadequate for being well-led.

- Leaders did not have the necessary capacity or capability to lead effectively.
- The practice had a vision but not all staff was aware of this and their responsibilities in relation to it.
- We identified a number of gaps in the arrangements for identifying, recording and managing risks. The practice had not assessed risk associated with premises and risk associated with infection control including no risk assessments for the control of substances hazardous to health or legionella. The practice failed to carry out electrical appliance testing since 2012 and there were no records of fire risk assessment, no logs of fire drills and fire equipment checks. Curtains in clinical rooms did not have dates of when they were last cleaned or replaced and there were no systems in place to do this.
- The practice had a number of policies and procedures to govern activity, but some of these were overdue a review. For example, the safeguarding policy had not been reviewed since 2012 and did not have up to date information or details of safeguarding contacts.
- Staff said they felt supported by the management team. However, one staff member told us they were overwhelmed with the workload and were finding it difficult to complete all duties in their contracted hours. They were not given protected time to complete additional tasks allocated to them.

Inadequate



Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The provider was rated as inadequate for safe, effective and well-led and good for caring and responsive. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good practice.

- The practice offered proactive, personalised care to meet the needs of the older people in its population. However, people did not have a named GP.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.

Inadequate



People with long term conditions

The provider was rated as inadequate for safe, effective and well-led and good for caring and responsive. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good practice.

- The practice had higher than average exception reporting for some clinical indicators. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). For example, exception reporting for diabetes was 32% compared to CCG average of 12% and national average of 11%.
- People did not have a named GP. However, staff told us patients with long-term conditions were invited to annual reviews to check their health and medicines needs were being met. For those patients with the most complex needs, the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.

Inadequate



Families, children and young people

The provider was rated as inadequate for safe, effective and well-led and good for caring and responsive. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good practice.

Inadequate



Summary of findings

- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages.
- The practice's uptake for the cervical screening programme was 76%, which was comparable to the national average of 82%.
- Appointments were available outside of school hours however there were no baby changing facilities.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

The provider was rated as inadequate for safe, effective and well-led and good for caring and responsive. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good practice.

- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Telephone appointments were available for patients who were unable to attend in person or who were unsure if their condition required attention.
- Health checks were available for new patients and those aged over 40 years.

Inadequate



People whose circumstances may make them vulnerable

The provider was rated as inadequate for safe, effective and well-led and good for caring and responsive. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good practice.

- Staff knew how to recognise signs of abuse in vulnerable adults and children, although administration staff did not have formal training in safeguarding adults. Staff would always raise concerns with the safeguarding lead in the practice. The safeguarding policy in the practice did not have correct and up to date contact details.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

Inadequate



Summary of findings

- There were arrangements to allow patients with no fixed address to register or to be seen by a clinician.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

People experiencing poor mental health (including people with dementia)

The provider was rated as inadequate for safe, effective and well-led and good for caring and responsive. The issues identified as inadequate overall affected all patients including this population group. There were, however, examples of good practice.

- 93% of patients diagnosed with dementia that had their care reviewed in a face to face meeting in the last 12 months, which is better than the national average of 84%.
- Performance for mental health related indicators was similar to the national average For example, 93% of patients with schizophrenia, bipolar affective disorder and other psychoses had had a comprehensive, agreed care plan documented in their records, in the preceding 12 months (CCG Average 92%, national average 88%).
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Inadequate



Summary of findings

What people who use the service say

The national GP patient survey results were published on January 2016. The results showed the practice was performing in line with local and national averages. Two-hundred and sixty-nine survey forms were distributed and 118 were returned. This represented 2.4% of the practice's patient list.

- 90% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 81% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 85% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 77% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received 38 patient Care Quality Commission comment cards. Thirty-six of which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Two comment cards raised concerns about delay in referrals to secondary care as well as clinicians being reluctant to prescribe specific medication. One comment card said there was a shortage of appointments and lack of continuity of care due to the frequent use of locum GPs.

We spoke with four patients and one member of the patient participation group (PPG) during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. They told us that conversations could be heard in the reception area, but they knew if they wanted to speak in private, they could ask the reception staff to do so.

Berwick Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP specialist adviser.

Background to Berwick Surgery

Berwick Surgery is based in a converted semi-detached house, located in a residential area of Rainham. The practice provides GP primary care services to approximately 4,900 people. Primary medical care is provided under a personal medical services (PMS) contract within NHS Havering Clinical Commissioning Group (CCG). The practice is registered with the Care Quality Commission (CQC) to care out the following regulated activities: treatment of disease, disorder or injury, maternity and midwifery services and family planning, diagnostic and screening procedures and surgical procedures.

There are two male GP partners. One of the senior partners was also the Clinical Director for Havering CCG. The GP partners did 11 clinical sessions between them from Monday to Friday. They were supported by locum GPs who did an additional four GP sessions between Monday and Friday. The practice employs one female part time nurse prescriber and one female part time healthcare assistant. There is one practice manager and seven part time administrative staff.

The practice was open between 8.00am and 6.30pm Monday to Friday. The practice was closed between 12.00pm and 1.00pm for lunch but the telephone lines remained open for patients. Appointments were from 8.30am to 11.30am every morning and from 4.00pm to 6pm

in the evening. Between 11.30am and 12.30pm, all clinical staff carried out telephone consultations. Out of hours the service is provided by a different provider between 6.30pm and 8am and can be accessed by calling the practice out of hours telephone number which is on the practice website and practice leaflet.

Information taken from the Public Health England practice age distribution shows the population distribution of the practice was similar to that of other practices in England. The life expectancy of male patients was the same as the CCG and national average of 79 years. The female life expectancy at the practice was 85 years, which is higher than the CCG average of 84 years and national average of 83 years.

Information published by Public Health England rates the level of deprivation within the practice population group as seven on a scale of one to 10. Level one represents the highest levels of deprivation and level 10 the lowest.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The provider had been inspected 6 September 2013 and was found to be compliant. Locations inspected prior to October 2014 did not have a rating.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 1 March 2016. During our visit we:

- Spoke with a range of staff (clinical and non-clinical) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?

- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out an analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, we saw an incorrect vaccine had been administered to a patient. As a result, further training was identified for the clinician.

Overview of safety systems and processes

The practice did not have systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. However, the policies were out of date and did not have the correct contact details of the safeguarding teams. The practice nurse was the lead for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their

responsibilities; however administration staff had not received training on adult safeguarding. GPs and the nurse were trained to child protection or child safeguarding level 3 in February 2013.

- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and could give examples of what their role was when chaperoning. We found that risk assessments for Disclosure and Barring Service (DBS) check were not in place for members of the reception team who acted as chaperone. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice had carried out a DBS check for the nurse, however there was no evidence of DBS check carried out for the healthcare assistant.
- The practice nurse was the infection control clinical lead and staff had not received infection control training since 2012. There was no infection control protocol in place and annual infection control audits were not being undertaken. The last infection control audit was conducted in 2013 and we saw evidence that action was taken to address any improvements identified as a result. The fridge was overstocked with vaccines and we saw mould had grown in the fridge as well as on packaging of some vaccines. Both plastic and fabric chairs were being used in the clinical rooms, although the fabric chairs appeared not to be damaged there were no systems in place to check chairs to prevent infection. The details on sharps bins were not filled in correctly to include start date or signatures. Although clinical staff could say when the sharps bins needed replacing. We were told a cleaner was contracted to clean twice a week, but there were no cleaning logs. There were no records of when curtains in consultation rooms were cleaned or needed cleaning and staff could not tell us when the cleaning or replacement was due.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). There was no written cold chain protocol in place to follow if the fridge temperatures went out of range. We found mould inside the fridge and on the packaging of vaccines. Processes were in place for handling repeat

Are services safe?

prescriptions which included the review of high risk medicines. We did not see evidence of the practice carrying out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored; however there were no systems in place to monitor their use. The practice nurse had recently qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. She received mentorship and support from the medical staff for this extended role. The Health Care Assistant was trained to administer vaccines and medicines, however we saw no evidence of patient specific prescription (PSD) or direction from a prescriber authorising them to administer the vaccines and medicines.

- We reviewed 12 personnel files and found appropriate recruitment checks had not been undertaken prior to employment. For example, a new member of staff did not have proof of identification or CV. Other personnel files did not include references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS).

Monitoring risks to patients

Risks to patients were not adequately assessed or managed.

- There was a health and safety policy available with a poster in the reception office, which identified local health and safety representatives. The practice had not carried out a fire risk assessment and we were told that monthly fire alarm tests were carried out but this was not recorded. We found the fire extinguishers were last checked in 2012 and were due to be checked in 2013. Electrical equipment had not been checked since 2012 to ensure the equipment was safe to use. Clinical

equipment was checked to ensure it was working properly. We saw no evidence of any other risk assessments in place to monitor safety of the premises. For example, there were no risk assessments for the control of substances hazardous to health or infection control or legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. We were told Locum GPs were used at least three days a week directly by the practice. However there was no locum induction pack and no background checks were carried out prior to them working.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- The practice had a defibrillator with pads and oxygen, however there were no masks. A first aid kit and accident book were available.
- There were emergency medicines available in the treatment rooms. However, we found 13 medicines and medical appliances out of date. Some items had expired in 2008. We were told that medicines were checked every three to four months but there was no log of this.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- Clinicians organised their own access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs. The practice did not have a system to ensure that these guidelines were followed through risk assessments, audits or random sample checks of patient records.
- The GPs told us they attended quarterly prescribing forums ran by the CCG, where guidelines were discussed. Benchmarking data is used at the meetings and the practice was identified for its low percentage of prescribing of ibuprofen and naproxen of all total non-steroidal anti-inflammatory drugs (NSAIDs). The practice told us they had improved their prescribing from 47% in June 2014 to 58% in June 2015, by proactively inviting patients to discuss switching their medication.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 92.9% of the total number of points available. The practice had higher than average exception reporting for some clinical indicators. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Including, Chronic Obstructive Pulmonary Disease (COPD) was 36%, compared to CCG average of 11% and national average of 12%. Exception reporting for diabetes was 32% compared to CCG average of 12% and national average of 11%. Exception reporting for cancer related indicators was 33% compared to CCG average of 10% and national average of 15% and chronic kidney diseases of 32% compared to CCG average of 7%

and national average of 8%. The practice were aware of this and had systems in place to contact patients to attend annual reviews. However, the practice told us patients were not attending review appointments.

Data from 2014/15 showed:

- Performance for diabetes related indicators was similar to the national average. For example, 92% of patients with diabetes had a blood sugar level of 64 mmol/mol or less in the preceding 12 months compared to 74% for CCG average and 78% for national average.
- Performance for mental health related indicators was similar to the national average. For example, 93% of patients with schizophrenia, bipolar affective disorder and other psychoses had had a comprehensive, agreed care plan documented in their records, in the preceding 12 months compared to 92% for CCG average and 88% for national average. The exception reporting for mental health was 10%.
- 94% of patients with COPD had had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months compared to the CCG average of 90% and 90% for national average.

There was no evidence of quality improvement, including a lack of clinical audits.

- There had been no clinical audits carried out in the last two years. We saw evidence of two sets of data collection, ready to be analysed and used for an audit.
- The practice participated in local and national benchmarking.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as health and safety and first aid. However, there was a lack of formal training
- We saw records which demonstrated that some staff received ongoing training and support. For example, the practice nurse administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered

Are services effective?

(for example, treatment is effective)

vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at clinical forums.

- Clinical staff benefitted from one half day of protected learning time each month and used this to attend relevant courses and seminars.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, basic life support and information governance. However, administration staff did not have adult safeguarding training and only two members of staff had had fire safety training completed in 2013.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. Although, clinical staff had not had any formal training on Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- Smoking cessation advice was available on the premises with the healthcare assistant. The healthcare assistant is a Level 2 trained stop smoking advisor. Between April 2014 and Feb 2016, 61 patients joined the stop smoking programme and 30 had quit in this period.

The practice's uptake for the cervical screening programme was 76%, which was comparable to the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 67% to 80% and five year olds from 61% to 81%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and

Are services effective?

(for example, treatment is effective)

NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and helpful to patients and treated them with dignity and respect.

- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Curtains and portable blinds were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.

We received 38 patient Care Quality Commission comment cards. Thirty-six of which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Two comment cards raised concerns about delay in referrals to secondary care as well as clinicians being reluctant to prescribe specific medication. One comment card said there was a shortage of appointments and lack of continuity of care due to the frequent use of locum GPs.

We spoke with four patients and one member of the patient participation group. They told us that conversations could be heard in the reception area, but they knew if they wanted to speak in private, they could ask the reception staff to do so. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was comparable to CCG and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 82% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 83% and the national average of 89%.

- 87% of patients said the GP gave them enough time compared to the CCG average of 81% and the national average of 87%.
- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 95%.
- 84% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 88% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 95% of patients said they found the receptionists at the practice helpful compared to the CCG average of 87% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 84% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 80% and the national average of 86%.
- 79% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 83% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. However, there were no notices to inform patients of this service.
- Information leaflets were available in easy read format.

Are services caring?

- There was a blood pressure machine in the reception area for patients to use at their convenience.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

Information about support groups was also available on the practice website. For example, the practice had an up to date list of dementia friendly organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 18 patients as carers (0.4% of the practice list). The practice

acknowledged this was not a true representation and believed they had more carers. The practice used the patient registration form to identify carers. However, the practice had not taken any further action to proactively identify carers. Written information was available to direct carers to the various avenues of support available to them. The practice offered carers a priority flu vaccination and would refer carers for counselling when this was suitable.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The lead GP is the clinical director for Havering CCG.

- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There was wheel-chair access but there is no disabled toilets or hearing loop. However, there were translation services available.
- Prescriptions could be ordered online, electronic prescriptions (EPS) and in person. People who are housebound can request prescriptions via telephone.
- Patients on the palliative care register had a fortnightly home visit.
- All patients with a long term condition were invited for a 6 monthly medication review with the GP. However, people did not always attend these.
- Minor surgery clinics are held on the last Thursday of every month. For example, the removal of warts.
- The practice have a private DNA testing service for patients registered in the practice as well as those in the CCG.
- There were two male GPs and no provision was made for patients to see a female GP.

Access to the service

The practice was open between 8.00am and 6.30pm Monday to Friday. The practice was closed between 12.00pm and 1.00pm for lunch but the telephone line remained open for patients. Appointments were from 8.30am to 11.30am every morning and from 4.00pm to 6pm in the evening. Between 11.30am and 12.30pm, all clinical staff carried out telephone consultations during this period.

Between 1.00pm and 4.00pm one GP was on call and the practice told us that patients could access the walk-in centre or go to the local Hub. The out of hours service is provided by a different provider and can be accessed by calling the practice out of hours telephone number which is on the practice website and practice leaflet. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to national averages.

- 81% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 90% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 81% of patients said the last time they wanted to see or speak to a GP or nurse from the surgery they were able to get an appointment compared to the national average of 76%.

All clinical staff had telephoning triage sessions at the end of their morning sessions. We saw that patients who needed to be seen after the telephone consultation were then booked into the afternoon session or the next day. On the day of inspection patient's told us that they liked this system and that this meant they were able to see a clinician if they needed to.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system on posters in the reception area and on their website.

We looked at four complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. Patients received a written response with an apology when appropriate.

Are services well-led?

Inadequate 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

There is no clear vision or guiding values. Staff were not aware of the visions or values.

- The practice had a mission statement but only the lead GP knew what it was. The mission statement was not displayed in the waiting areas and staff were not aware of it.
- The practice did not have a written strategy and supporting business plan to reflect the vision and values. Staff did not understand how their role contributes to achieving the strategy.

Governance arrangements

The practice lacked a clear governance framework to delivery good quality care.

- We identified a number of gaps in the arrangements for identifying, recording and managing risks. The practice had not assessed risk associated with premises and risk associated with infection control including no risk assessments for the control of substances hazardous to health or legionella. The practice failed to carry out electrical appliance testing since 2012 and there were no records of fire risk assessment, no logs of fire drills and fire equipment checks. Curtains in clinical rooms did not have dates of when they were last cleaned or replaced and there were no systems in place to do this.
- Additionally, the practice had not assessed the risk in the absence of disclosure and barring checks (DBS checks) for members of the practice team who provided a chaperone service. The practice did not keep a record of DBS for the healthcare assistant.
- The practice did not have systems in place for the safe management of medicines. GPs were not using PSDs to authorise the healthcare assistant to administer vaccines and medicines to people. There were no systems to track blank prescriptions. We saw oxygen on the premises but there were no masks. We found 13 medicines and medical appliances out of date, including emergency medicines. The fridge was overstocked with vaccines and had mould in the fridge as well as the packaging of vaccines.
- The practice did not operate an effective programme of clinical audits. While some data collection was carried

out, we saw no evidence of completed audits. There was no quality improvement programme including continuous clinical and internal auditing to make improvements.

- The practice had some policies and procedures in place to govern activity and these were available to all staff. However, there were some policies which were overdue a review, for example the Safeguarding policy was a generic policy which had not been up dated since 2012 and administration staff did not have adult safeguarding training and GPs did not have further update training since 2013.
- A comprehensive understanding of the performance of the practice was maintained through weekly clinical meetings and practice meetings.
- There was a staffing structure and that staff were aware of their own roles and responsibilities.

Leadership and culture

Leaders did not have the necessary capacity or capability to lead effectively. On the day of inspection, we did not see evidence of quality and safety as top priorities for the leadership team. Staff told us the partners were approachable and always took the time to listen to all members of staff. However, one member of staff told us they felt overwhelmed with the workload and was working over their contracted hours daily. They did not get protected time to complete additional tasks.

There was a leadership structure in place and staff felt supported by management.

- Staff told us the practice held weekly meetings for administrative staff, and whole practice meetings were held every six to eight weeks.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. For example, administration staff had suggested changing the afternoon

Are services well-led?

Inadequate 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

appointment times to start from 4pm to coincide with when the evening staff started their shift. This was taken on-board by the practice management team and the change was implemented.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through annual patient surveys and complaints received. Although the PPG did not meet regularly, the PPG chairperson told us they met ad hoc depending on what concerns were raised by patients. The practice carried out patient surveys and these were discussed in the PPG meetings. For example, patients reported the toilet facilities were not adequate in the practice and the PPG raised this with the practice. However, the practice said there was not enough funding to have the toilets re-fitted. As a result, the PPG raised a large sum of money through a fundraising event. The money raised was used to refurbish the shared staff and patient toilet facilities in the practice. Money left over was used to buy blood pressure monitors, which patients could hire from the practice when they needed to.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users. They had failed to identify the risks associated with the lack of proper and safe management of medicines. The provider had failed to assess the risk of, prevent, detect and control the spread of infections. The provider failed to assess the risk associated with fire and COSHH. The provider had failed to ensure that necessary pre-employment checks had been completed on staff. The provider had failed to risk assess staff needing a DBS check to carry out chaperoning duties. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Effective systems and processes were not in place to enable the provider to identify and assess risks to health, safety and welfare of people who use the service, such as risk assessments in the absence of disclosure and barring (DBS) checks for staff; including staff who chaperone.

This section is primarily information for the provider

Requirement notices

There were no systems in place to monitor the risk from infection control or fire risk.

The provider had not completed clinical audits to improve patient safety and outcomes.

The provider did not ensure that all policies and procedures to govern activity were practice specific or always up to date.

The provider did not have effective systems in place to securely monitor blank prescriptions.

Records relating to people employed by the service were not in place for all staff members. We found that records were limited and lacked sufficient information.

This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Regulated activity

Diagnostic and screening procedures
Family planning services
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

How the regulation was not being met:

The provider had failed to ensure that processes were in place to ensure staff have appropriate and current registration with a professional body, and had not ensured that information specific to schedule three was in place.

This was a breach of regulation 19(1)(3) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.